		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032862

Facility Name: DANVILLE CARE CENTER

Address: 1701 N. BOWMAN AVE (Number) DANVILLE (City) 61832 (Zip Code)

County: VERMILLION

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-3532095

Date of Initial License for Current Owners: 10/01/87

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code ____		[ ]	Corporation	[ ]	Other ____
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other ____		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD., 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,797	4,824	8
9	SNF/PED					9
10	ICF	40,435	4,574	1,085	46,094	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,435	4,574	5,882	50,918	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.75%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 4,797

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	239,959	13,110	9,356	262,425		262,425	0	262,425			1
2	Food Purchase		235,080		235,080		235,080	(13,677)	221,403			2
3	Housekeeping	142,829	36,423	0	179,252		179,252	542	179,794			3
4	Laundry	113,635	33,903	2,159	149,697		149,697	0	149,697			4
5	Heat and Other Utilities			129,395	129,395		129,395	874	130,269			5
6	Maintenance	31,217	32,491	32,657	96,365		96,365	3,158	99,523			6
7	Other (specify):* scavenger			8,737	8,737		8,737	0	8,737			7
8	**TOTAL General Services**	527,640	351,007	182,304	1,060,951	0	1,060,951	(9,103)	1,051,848			8
	B. Health Care and Programs											
9	Medical Director	0		7,875	7,875		7,875	0	7,875			9
10	Nursing and Medical Records	1,682,866	211,244	60,572	1,954,682		1,954,682	23,211	1,977,893			10
10a	Therapy	51,929		1,653	53,582		53,582	0	53,582			10a
11	Activities	75,827		608	76,435		76,435	0	76,435			11
12	Social Services	64,619		3,256	67,875		67,875	0	67,875			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,875,241	211,244	73,964	2,160,449	0	2,160,449	23,211	2,183,660			16
	C. General Administration											
17	Administrative	80,150		86,300	166,450		166,450	(25,632)	140,818			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			57,400	57,400		57,400	12,986	70,386			19
20	Dues, Fees, Subscriptions & Promotions			34,268	34,268		34,268	(10,672)	23,596			20
21	Clerical & General Office Expenses	146,800	23,416	224,422	394,638		394,638	(57,920)	336,718			21
22	Employee Benefits & Payroll Taxes			405,571	405,571		405,571	31,713	437,284			22
23	Inservice Training & Education			0	0		0	0	0			23
24	Travel and Seminar			1,760	1,760		1,760	11,629	13,389			24
25	Other Admin. Staff Transportation			12,843	12,843		12,843	13,194	26,037			25
26	Insurance-Prop.Liab.Malpractice			94,519	94,519		94,519	6,053	100,572			26
27	Other (specify):*			0	0		0	0	0			27
28	**TOTAL General Administration**	226,950	23,416	917,083	1,167,449	0	1,167,449	(18,649)	1,148,800			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,629,831	585,667	1,173,351	4,388,849	0	4,388,849	(4,541)	4,384,308			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number DANVILLE CARE CENTER #0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			75,890	75,890		75,890	184,588	260,478			30
31	Amortization of Pre-Op. & Org.				0		0	26,680	26,680			31
32	Interest			44,624	44,624		44,624	536,050	580,674			32
33	Real Estate Taxes			60,926	60,926		60,926	0	60,926			33
34	Rent-Facility & Grounds			806,180	806,180		806,180	(798,725)	7,455			34
35	Rent-Equipment & Vehicles			3,698	3,698		3,698	0	3,698			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			991,318	991,318	0	991,318	(51,407)	939,911			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		1,797	81,937	83,734		83,734	(3,540)	80,194			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			109,500	109,500		109,500	0	109,500			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	1,797	191,437	193,234	0	193,234	(3,540)	189,694			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,629,831	587,464	2,356,106	5,573,401	0	5,573,401	(59,488)	5,513,913			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,433)	30		9
10	Interest and Other Investment Income	(113)	32		10
11	Discounts, Allowances, Rebates & Refunds	(13,045)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(632)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(13,807)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(9,772)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,458)	20		28
29	Other-Attach Schedule SEE PAGE 5A	2,262	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (45,998)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(13,490)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (13,490)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (59,488)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

DANVILLE CARE CENTER

ID# 0032862

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2262	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,262		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,677)	0	0	0	0	0	0	0	0	0	0	(13,677)	2
3	Housekeeping	0	0	542	0	0	0	0	0	0	0	0	542	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	874	0	0	0	0	0	0	0	0	874	5
6	Maintenance	2,262	0	896	0	0	0	0	0	0	0	0	3,158	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,415)	0	2,312	0	0	0	0	0	0	0	0	(9,103)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	23,211	0	0	0	0	0	0	0	0	23,211	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	23,211	0	0	0	0	0	0	0	0	23,211	16
	C. General Administration													
17	Administrative	0	(86,300)	60,668	0	0	0	0	0	0	0	0	(25,632)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	12,712	274	0	0	0	0	0	0	0	12,986	19
20	Fees, Subscriptions & Promotions	(11,230)	0	558	0	0	0	0	0	0	0	0	(10,672)	20
21	Clerical & General Office Expenses	(13,807)	(176,613)	130,237	2,263	0	0	0	0	0	0	0	(57,920)	21
22	Employee Benefits & Payroll Taxes	0	0	25,586	6,127	0	0	0	0	0	0	0	31,713	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	10,678	951	0	0	0	0	0	0	0	11,629	24
25	Other Admin. Staff Transportation	0	0	10,950	2,244	0	0	0	0	0	0	0	13,194	25
26	Insurance-Prop.Liab.Malpractice	0	0	6,053	0	0	0	0	0	0	0	0	6,053	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(25,037)	(262,913)	257,442	11,859	0	0	0	0	0	0	0	(18,649)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(36,452)	(262,913)	282,965	11,859	0	0	0	0	0	0	0	(4,541)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(9,433)	190,136	3,885	0	0	0	0	0	0	0	0	184,588	30
31	Amortization of Pre-Op. & Org.	0	26,680	0	0	0	0	0	0	0	0	0	26,680	31
32	Interest	(113)	536,064	99	0	0	0	0	0	0	0	0	536,050	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(806,180)	7,455	0	0	0	0	0	0	0	0	(798,725)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,546)	(53,300)	11,439	0	0	0	0	0	0	0	0	(51,407)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(68,582)	0	65,042	0	0	0	0	0	0	0	(3,540)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	(68,582)	0	65,042	0	0	0	0	0	0	0	(3,540)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(45,998)	(384,795)	294,404	76,901	0	0	0	0	0	0	0	(59,488)	45

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRADLEY ALTER	22.83	SCHEDULE ATTACHED		CERTIFIED HEALTI	SKOKIE	BOOKEEPING/
HOWARD GELLER	38.04			MANAGEMENT		MANAGEMENT
CYNTHIA CHOW	39.13					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	MANAGEMENT FEES	$ 86,300	CERTIFIED HEALTH MANAGEMENT		$	$ (86,300)	1
2	V		21	BOOKKEEPING FEES	180,620	" " ".			(180,620)	2
3	V		39	THERAPY	68,582	" " ".			(68,582)	3
4	V									4
5	V									5
6	V									6
7	V		34	RENT	806,180	DANVILLE CARE CENTER LLC			(806,180)	7
8	V		30	DEPRECIATION		" " " "		190,136	190,136	8
9	V		32	INTEREST		" " " "		536,064	536,064	9
10	V		21	OFFICE EXPENSES		" " " "		4,007	4,007	10
11	V		31	AMORTIZATION		" " " "		26,680	26,680	11
12	V									12
13	V									13
14	Total				$ 1,141,682			$ 756,887	$ * (384,795)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$			$ 542	$ 542	15
16	V	5	ELECTRICITY & GAS				874	874	16
17	V	6	MAINTENANCE				896	896	17
18	V	10	NURSING/MEDICAL RECORDS				23,211	23,211	18
19	V	17	ADMIN SALARIES				60,668	60,668	19
20	V	19	PROFESSIONAL FEES				12,712	12,712	20
21	V	20	FEES, SUBSCRIPTIONS				558	558	21
22	V	21	OFFICE EXPENSE				130,237	130,237	22
23	V	22	EMPLOYEE BENEFITS				25,586	25,586	23
24	V	24	TRAVEL/SEMINAR				10,678	10,678	24
25	V	25	TRANSPORTATION				10,950	10,950	25
26	V	26	INSURANCE				6,053	6,053	26
27	V	30	DEPRECIATION				3,885	3,885	27
28	V	32	INTEREST				99	99	28
29	V	34	OFFICE RENT				7,455	7,455	29
30	V	35	EQUIPMENT RENT				0		30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 294,404	$ * 294,404	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	THERAPY	$			$ 65,042	$ 65,042	15
16	V	19	PROFESSIONAL FEE				274	274	16
17	V	21	OFFICE EPXNESE				2,263	2,263	17
18	V	22	EMPLOYEE BENEFITS				6,127	6,127	18
19	V	24	TRAVEL/SEMINARS				951	951	19
20	V	25	TRANSPORTATION				2,244	2,244	20
21	V	35	EQUIPMENT RENT						21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 76,901	$ * 76,901	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	$ 81,575	17-3	1
2	HOWARD GELLER		ADMINISTRATIVE		SCHEDULE ATTACHED			MGMT FEE	4,175	19-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 85,750		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	279,537	8	$ 3,000	$	50,467	$ 542	1
2	5	ELECTRICITY & GAS	" " "	279,537	8	4,839		50,467	874	2
3	6	MAINTENANCE	" " "	279,537	8	4,965		50,467	896	3
4	10	NURSING/MEDICAL RECORD	" " "	279,537	8	128,566	128,566	50,467	23,211	4
5	17	ADMIN SALARIES	" " "	279,537	8	336,038	336,038	50,467	60,668	5
6	19	PROFESSIONAL FEES	" " "	279,537	8	70,412		50,467	12,712	6
7	20	FEES, SUBSCRIPTIONS	" " "	279,537	8	3,089		50,467	558	7
8	21	OFFICE EXPENSE	" " "	279,537	8	721,384	572,980	50,467	130,237	8
9	20	EMPLOYEE BENEFITS	" " "	279,537	8	141,722		50,467	25,586	9
10	24	TRAVEL/SEMINAR	" " "	279,537	8	59,144		50,467	10,678	10
11	25	TRANSPORTATION	" " "	279,537	8	60,651		50,467	10,950	11
12	26	INSURANCE	" " "	279,537	8	33,528		50,467	6,053	12
13	30	DEPRECIATION	" " "	279,537	8	21,518		50,467	3,885	13
14	32	INTEREST	" " "	279,537	8	549		50,467	99	14
15	34	OFFICE RENT	" " "	279,537	8	41,293		50,467	7,455	15
16	35	EQUIPMENT RENT	" " "	279,537	8				0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,630,698	$ 1,037,584		$ 294,404	25

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CHM THERAPY
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	THERAPY	USAGE	100	5	$ 271,007	$ 271,007	24	$ 65,042	1
2	19	PROFESSIONAL FEE	USAGE	100	5	1,143		24	274	2
3	21	OFFICE EPXNESE	USAGE	100	5	9,430		24	2,263	3
4	22	EMPLOYEE BENEFITS	USAGE	100	5	25,530		24	6,127	4
5	24	TRAVEL/SEMINARS	USAGE	100	5	3,963		24	951	5
6	25	TRANSPORTATION	USAGE	100	5	9,348		24	2,244	6
7	35	EQUIPMENT RENT	USAGE	100	5				0	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 320,421	$ 271,007		$ 76,901	25

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BARRY KIRSCHEMBAUM	X		MORTGAGE	$52,439.00	1/1/98	$ 6,300,000	$ 5,980,111	1/1/23	8.9000	$ 536,064	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				371,680		PRIME+	42,497	6
7												7
8	RELATED PARTY/INS FIN.	X									2,226	8
9	TOTAL Facility Related				$52,439.00		$ 6,300,000	$ 6,351,791			$ 580,787	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 6,300,000	$ 6,351,791			$ 580,787	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 59,005	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 59,372	2
3. Under or (over) accrual (line 2 minus line 1).		$ 367	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 60,559	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 60,926	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	48,421	8
	1997	50,382	9
	1998	51,543	10
	1999	57,848	11
	2000	59,372	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DANVILLE CARE CENTER COUNTY VERMILLION

FACILITY IDPH LICENSE NUMBER 0032862

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 X40 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-33-200-016-0060		$ 35,669.38	$ 35,669.38
2.	18-34-100-005-0060		$ 23,702.34	$ 23,702.34
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 59,371.72	$ 59,371.72

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1998	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1998		$ 2,954,225	$ 152,666	39	$ 152,666	$	$ 610,670	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1989	34,167	1,085	30	1,139	54	13,372	9
10	LEASEHOLD IMPROVEMENTS			1990	17,344	551	30	578	27	6,444	10
11	LEASEHOLD IMPROVEMENTS			1991	45,376	1,441	30	1,513	72	15,418	11
12	LEASEHOLD IMPROVEMENTS			1992	12,043	382	30	401	19	3,705	12
13	LEASEHOLD IMPROVEMENTS			1993	9,213	236	30	307	71	2,300	13
14	LEASEHOLD IMPROVEMENTS			1994	8,304	213	39	213		1,607	14
15	NURSING STATION			1995	14,331	367	39	367		2,310	15
16	DOOR/LIGHT FIXTURES			1995	17,592	451	39	451		2,837	16
17	FIRE ALARM & ELECTRICAL WORK			1995	2,420	62	39	62		390	17
18	SHOWER/BATH CONST.			1995	4,704	121	39	121		761	18
19	NURSECALL REPAIR			1996	1,655	43	39	43		256	19
20	SMOKE DETECTORS/LIGHT FIXTURES/DOOR			1996	5,894	150	39	150		872	20
21	RESURFACE PARKING AREA			1996	12,910	861	15	861		4,735	21
22	ROOF REPAIR			1966	12,742	327	39	327		1,676	22
23	WARDROBE UNITS			1996	8,361	214	39	214		1,079	23
24	FLOORING			1996	2,444	63	39	63		317	24
25	CARPET/WALLPAPER/BUMPER GUARDS/COVE BASE			1997	19,014	488	39	488		2,234	25
26	PARKING LOT REPAIR			1997	1,500	100	15	100		450	26
27	PAVILION CONST.			1997	8,297	212	39	212		992	27
28	THERAPY ROOM ADDITION			1998	320,230	8,211	39	8,211		24,976	28
29	NORTH WING RENOVATION			1998	65,143	1,670	39	1,670		5,080	29
30	BUMPER GUARDS			1998	9,285	238	39	238		943	30
31	CEILING REPAIR/DRYWALL/TILE			1999	17,083	438	39	438		918	31
32	NURSE CALL/FIRE ALARM SYSTEM			1999	5,616	144	39	144		368	32
33	ROOF REPAIR/AIR EXHAUSTS			1999	7,095	183	39	183		468	33
34	LANDSCAPING			1999	12,535	836	15	836		2,089	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR CONDITIONER	2000	$ 3,436	$ 0	20	$ 172	$ 172	$ 258	37
38	CARPET/COVE BASE/WALLPAPER	2000	9,734	3,226	20	487	(2,739)	730	38
39	BATHROOM REPAIR/REMODEL	2000	11,104	404	27.5	404		714	39
40	HOT TUB ROOM REPAIR/REMODEL	2000	6,700	244	27.5	244		426	40
41	ALARMA SYSTEM/DOORS/CAMERAS	2000	15,171	552	27.5	552		970	41
42	NORTH WING RENOVATION	2000	4,809	175	27.5	175		303	42
43	WATER HEATER VALVE	2000	1,026	37	27.5	37		69	43
44	SECURITY DOOR	2001	693	12	27.5	12		12	44
45	WATER HEATER	2001	684	11	27.5	11		11	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,682,880	$ 176,414		$ 174,090	$ (2,324)	$ 710,760	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 460,025	$ 41,303	$ 46,003	$ 4,700		$ 242,181	71
72	Current Year Purchases	26,797	3,829	1,340	(2,489)		1,340	72
73	Fully Depreciated Assets	41,241			0		41,241	73
74	RELATED PARTY	346,639	41,355	34,664	(6,691)			74
75	TOTALS	$ 874,702	$ 86,487	$ 82,007	$ (4,480)		$ 284,762	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINT DEPT	1995 DODGE VAN	1994	$ 19,595	$	$ 0	$ 0		$	76
77	PATIENT TRANS	1996 FORD WAGON	2000	21,907	7,010	4,381	(2,629)	5 YRS	11,391	77
78							0			78
79							0			79
80	TOTALS			$ 41,502	$ 7,010	$ 4,381	$ (2,629)		$ 11,391	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,949,084	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 269,911	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 260,478	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,433)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,006,913	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 3,698 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$ 43,486		$	$		$ 43,486	1
2	Licensed Speech and Language Development Therapist	39-3	hrs	1,688					1,688	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs	29,836					29,836	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): respiratory therapy	39-3		6,927					6,927	13
14	TOTAL			$ 81,937		$	$		$ 81,937	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 205,000)	1,273,032		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	136,257		6
7	Other Prepaid Expenses	(25,910)		7
8	Accounts Receivable (owners or related parties)	32,073		8
9	Other(specify): R/E ESCROW	186,757		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,602,209	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	728,656		15
16	Equipment, at Historical Cost	547,657		16
17	Accumulated Depreciation (book methods)	(535,606)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 740,707	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,342,916	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 589,347	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,050		28
29	Short-Term Notes Payable	371,680		29
30	Accrued Salaries Payable	154,493		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,868		31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,559		32
33	Accrued Interest Payable	1,763		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,197,760	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	657,090		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 657,090	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,854,850	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 488,066	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,342,916	$ 0	48

***(See instructions.)**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 143,096	1
2	Restatements (describe):		2
3	Adj from prior year	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 143,099	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	344,967	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 344,967	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 488,066	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,796,573	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,796,573	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	106,509	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 106,509	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	113	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 113	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	13,045	28
28a	VENDING COMMISSIONS	2,128	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,173	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,918,368	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,060,951	31
32	Health Care	2,160,449	32
33	General Administration	1,167,449	33
	B. Capital Expense		
34	Ownership	991,318	34
	C. Ancillary Expense		
35	Special Cost Centers	83,734	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,573,401	40
41	**Income before Income Taxes (line 30 minus line 40)****	344,967	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 344,967	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,040	2,080	$ 49,118	$ 23.61	1
2	Assistant Director of Nursing	1,226	1,250	21,278	17.02	2
3	Registered Nurses	9,247	9,576	167,547	17.50	3
4	Licensed Practical Nurses	30,884	31,948	469,215	14.69	4
5	Nurse Aides & Orderlies	94,029	96,959	906,684	9.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,781	4,956	51,929	10.48	8
9	Activity Director	1,459	1,590	16,589	10.43	9
10	Activity Assistants	9,676	9,892	59,238	5.99	10
11	Social Service Workers	7,877	8,020	64,619	8.06	11
12	Dietician					12
13	Food Service Supervisor	3,112	3,160	27,871	8.82	13
14	Head Cook	13,598	14,586	102,777	7.05	14
15	Cook Helpers/Assistants	16,039	16,839	109,311	6.49	15
16	Dishwashers					16
17	Maintenance Workers	3,141	3,261	31,217	9.57	17
18	Housekeepers	19,031	20,103	142,829	7.10	18
19	Laundry	17,723	18,627	113,635	6.10	19
20	Administrator	1,960	2,080	41,912	20.15	20
21	Assistant Administrator	1,960	2,080	38,238	18.38	21
22	Other Administrative	4,000	4,160	70,253	16.89	22
23	Office Manager	3,928	4,271	56,258	13.17	23
24	Clerical	2,946	2,966	20,289	6.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,752	1,856	20,073	10.82	31
32	Other Health C: transport aide	3,326	3,462	25,486	7.36	32
33	Other(specify) care plan coord	1,876	1,900	23,465	12.35	33
34	TOTAL (lines 1 - 33)	254,611	265,622	$ 2,629,831 *	$ 9.90	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 9,005	1-3	35
36	Medical Director		7,875	9-3	36
37	Medical Records Consultant		4,585	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		2,206	10-3	39
40	Physical Therapy Consultant		501	10a-3	40
41	Occupational Therapy Consultant		263	10a-3	41
42	Respiratory Therapy Consultant		480	10a-3	42
43	Speech Therapy Consultant		125	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		3,256	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 28,296		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	325	$ 13,665	10-3	50
51	Licensed Practical Nurses	564	17,839	10-3	51
52	Nurse Aides	146	3,596	10-3	52
53	TOTAL (lines 50 - 52)	1,035	$ 35,100		53

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KATHY PICKERING	ADMIN		$ 41,912
TONIE MCKNOWN	ASST ADMIN		38,238
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,150

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 86,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 86,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK,BOKOR,KAGDA	ACCTG	$ 7,700
R.PEELO & ASSOC.	ACCTG	3,750
PERSONNEL PLANNERS	HR CONSULT	3,756
PAYMASTER/MILLINEUM	DATA PROCESSING	5,382
CERTIFIED HEALT	ADMIN CONSULT	24,303
MICHAEL BEST&FRIEDRICH	LEGAL	3,009
ROSENTHAL/SCHANFIELD	LEGAL	1,377
SCHWARTZ/FREEMAN	LEGAL	677
STONE, MAGUIRE & BENJAMIN	LEGAL	1,246
WINSTON & STRAWN	LEGAL	6,200
RELATED PARTY		12,986
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 70,386

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 83,212
Unemployment Compensation Insurance	37,365
FICA Taxes	201,182
Employee Health Insurance	83,703
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	109
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
RELATED PARTY	31,713
TOTAL (agree to Schedule V, line 22, col.8)	$ 437,284

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,282
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	11,230
TRUST FEES/FRANCHISE TX/ETC	0
CONTRIBUTIONS	0
DUES & SUBSCRIPTIONS	9,565
LICENSES & PERMITS	2,191
RELATED PARTY	558
Less: Public Relations Expense	(0)
Non-allowable advertising	(9,772)
Yellow page advertising	(1,458)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,596

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	913
Seminar Expense	
	847
RELATED PARTY	11,629
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,389

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1996	$ 4,895	3	$ 1,632	$ 816	$	$	$	$	$	$	$
2	PAINT/DECORATING	1997	19,438	3	6,479	6,479	3,240						
3	PAINT/DECORATING	1998	7,750	3	1,292	2,583	2,583	1,292					
4	PAINT/DECORATING	1999	2,909	3		485	970	970	484				
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 34,992		$ 9,403	$ 10,363	$ 6,793	$ 2,262	$ 484	$	$	$	$

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LTC $9,008

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? NO

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 806 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 109,500
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: DANVILLE CARE CENTER **#0032862** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,005	
	REPAIRS & MAINTENANCE		351	
			0	9,356
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,159	
			0	2,159
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		23,290	
	ELECTRICITY		77,667	
	WATER		28,438	
	CABLE TV - LOBBY		0	
			0	129,395
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		10,201	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		18,544	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,680	
	FIRE SERVICE		2,232	
			0	
			0	
			0	32,657
7	**OTHER**			
	SCAVENGER		8,737	
	SECURITY SERVICE		0	8,737
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,875	7,875

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	35,100	
	LABORATORY & XRAY EXPENSE		425	
	PURCHASED SERVICES		8,318	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,585	
	PHARMACY CONSULTANT	XVIII B 39-2	2,206	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	NURSE PROGRAM CONSULT		9,938	
			0	60,572
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	284	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	501	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	263	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	480	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	125	1,653
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	ACTIVITY PROGRAM EXP		608	608
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,256	
			0	3,256
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DANVILLE CARE CENTER **#0032862** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	86,300	86,300
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,382	
	ADMINISTRATIVE CONSULTANTS	XIX C	24,303	
	PROFESSIONAL FEES	XIX C	27,715	
			0	57,400
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	9,772	
	EMPLOYEE WANT ADS	XIX F	11,282	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	9,565	
	LICENSES & PERMITS	XIX F	2,191	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,458	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	34,268
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		6,039	
	EQUIPMENT REPAIR & MAINTENANCE		475	
	OUTSIDE CLERICAL SERVICES		180,620	
	PENALTIES / OVERDRAFT CHARGES	VI 18	13,807	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		553	
	TELEPHONE		19,526	
	MESSENGER SERVICE		0	
	POSTAGE		3,402	224,422

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	201,182	
	UNEMPLOYMENT COMPENSATION	XIX D	37,365	
	WORKERS COMPENSATION INSURANC	XIX D	83,212	
	HOSPITALIZATION INSURANCE	XIX D	83,703	
	EMPLOYEE BENEFITS - OTHER	XIX D	109	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	405,571
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS			0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	847	
	TRAVEL	XIX G	913	
			0	
			0	1,760
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		12,843	12,843
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		94,519	94,519
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,173,351

DANVILLE CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	235,080
LESS SALES TAX	(632)
NET FOOD	235712
TOTAL PATIENT CENSUS	50,918
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	152754
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	152754
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	152754
NET FOOD	235712
DIVIDE TOTAL MEALS/YEAR	152754
COST PER MEAL	1.54
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	0

DANVILLE CARE CENTER
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S									5,819,348	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	2,160,449	405,571	413,749	149,697	497,505	761,878	109,500	991,318		2,629,831
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	0		0			0		0		
CABLE TV			0			0				
CONTRACT NURSING										35,100
INTEREST INCOME							(113)			
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(86,300)		86,300		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						0	0			
DISCOUNTS LOST							0			
AMORT-COMP SOFTWARE								0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	0	0	0	0	0	0	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	0	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	2,160,449	405,571	413,749	149,697	497,505	675,578	109,387	1,077,618	5,489,554	2,664,931
PER FINANCIAL STATEMENTS	0	0	0	0	0	0	0	0	329,794	0
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									0	

DANVILLE CARE CENTER - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		73,000			0			73,000	0		
CENSUS DAYS		50,918			0			50,918	0		
OCCUPANCY %		69.75%			#DIV/0!				#DIV/0!		
SALARIES											
TOTAL General Services	8-1	527,640	9.57%	10.36				527,640			
Social Services	12-1	64,619	1.17%	1.27				64,619			
TOTAL Health Care and Programs	16-1	########	34.01%	36.83				########			
Clerical & General Office Expenses	21-1	146,800	2.66%	2.88				146,800			
TOTAL General Administration	28-1	226,950	4.12%	4.46				226,950			
TOTAL Operation Expense	29-1	########	47.69%	51.65				########			
ADJUSTED TOTALS											
Food	2-8	221,403	4.02%	4.35				221,403			
Heat and Other Utilities	5-8	130,269	2.36%	2.56				130,269			
Maintenance	6-8	99,523	1.80%	1.95				99,523			
TOTAL General Services	8-8	########	19.08%	20.66				########			
Administrative	17-8	140,818	2.55%	2.77				140,818			
Directors Fees	18-8	0	0.00%	0.00				0			
Professional Services	19-8	70,386	1.28%	1.38				70,386			
Fees, Subscriptions, Promotions	20-8	23,596	0.43%	0.46				23,596			
License Fee-IDPA	Pg21	0	0.00%	0.00				0			
License Fee-Other	Pg21	2,191	0.04%	0.04				2,191			
Clerical & General Office Expenses	21-8	336,718	6.11%	6.61				336,718			
Employee Benefits & Payroll Taxes	22-8	437,284	7.93%	8.59				437,284			
Payroll Taxes	Pg21	238,547	4.33%	4.68				238,547			
W/C Insurance	Pg21	83,212	1.51%	1.63				83,212			
Health Insurance	Pg21	83,703	1.52%	1.64				83,703			
Inservice Training & Education	23-8	0	0.00%	0.00				0			
Travel and Seminar	24-8	13,389	0.24%	0.26				13,389			
Other Admin. Staff Transportation	25-8	26,037	0.47%	0.51				26,037			
Insurance-Prop.Liab.Malpractice	26-8	100,572	1.82%	1.98				100,572			
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	########	20.83%	22.56				########			
TOTAL Operation Expense	29-8	########	79.51%	86.11				########			
Real Estate Taxes	33-3	60,926	1.10%	1.20				60,926			
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	########	100.00%	**108.29**				########			
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1888836	34.26%	**37.10**	#DIV/0!	#DIV/0!	**#DIV/0!**	#DIV/0!	#DIV/0!	#DIV/0!	**#DIV/0!**

DANVILLE CARE CENTER - DIAGNOSTICS - 12/31/2001

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 2262 from Page 22 and 0 from Page 3 Line 6-3.
Ancillaries on Page 4 Line39-6 DOES NOT EQUAL Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-536163
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-194021
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
#VALUE!
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 DOES NOT EQUAL Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.